INOVA FAIRFAX HOSPITAL

Admission Date: 4/20/2009 5:18 PM (ET)
Patient Name: W[redacted] N[redacted]
MRN: 04305493
Account Number: 037373672
Location: W5E / W5E-W501-FW501-01

Patient Information - MRN # 04305493 - W[redacted], N[redacted]

Name:	N[redacted] W[redacted]	**Admission Date:**	4/20/2009 5:18 PM (ET)
MRN:	04305493	**Account Number:**	037373672
Date of Birth:	[redacted]2008 (age 5 month(s))	**Social Security Number:**	
Gender:	Male	**Marital Status:**	Single
Primary Diagnosis:	TRAUMATIC SUBDURAL HEM	**Secondary Diagnosis:**	
Address:	[redacted] ALEXANDRIA, VA[redacted]	**Home:** **Work:** **Alternative:**	(571) 332-1201
Admitting Physician:	AGARWAL, SWATI	**Attending Physician:**	AGARWAL, SWATI
Readmit:	No	**Last Discharge Date:**	
Primary Plan Description:	BC CAREFIRST NCA 080	**Primary Plan Number:**	XIP901804718
Secondary Plan Description:		**Secondary Plan Number:**	

Assessment Notes - MRN # 04305493 - W[redacted], N[redacted]

Assessment Note Created By:	Sweatt, Layne	**Department:**	Case Management
Assessment Note Created On:	4/24/2009 2:09 PM (ET)		

Notes:

SOCIAL WORK NOTE

4/24/2009 1400

SW left a message for Fairfax County Child Protective Services worker requesting an update on investigation/situation. Also, on the message, asked about any services (such as counseling) through victim services that might be available to this family.

SW continues to support family and follow this situation. Met with father who said that he and his wife continue to meet with Dr. Kronen, psychiatrist, and that this has been helpful. Mother more interactive, involved, and rested today, per father.

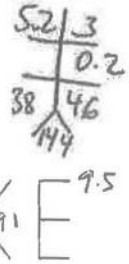
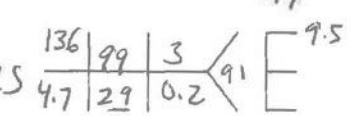
Layne Sweatt, LCSW
x7968

Layne Sweatt
7968
4/24/09

PICU Resident Progress Note

Friday, April 24, 2009

Name: W[redacted] N[redacted] Room: 501 Age: 4.5 months
DOB: [redacted]2008 MRN: 4305493 Admit Date: 4/20/2009
Wt: 6.8kg PICU admit: 4/20/2009

Problem List: 1. subdural hematoma 2. b/l retinal hemorrhages 3. NAT 4. Right focal seizures	**Allergies:** NKDA , NKFA **Lines/Tubes/Drains:** 1. PIV
Neuro: optho c/s showed retinal hemorrhages, neuro c/s EEG and dilantin level, 4/22 R sided focal clonic movements, 4/23 generalized sz **Exam:** decreased tone, drowsy, pinpoint pupils, decreased mvt of R side > L 4/21 CT head stable SDH 4/22 CT head stable SDH 4/22 Dilantin levels 10, 27 4/23 Dilantin level 20, Phenobarbital 25 (nl) -> 30 4/24 Phenobarbital 48	1. Phenobarbital 10mg IV q12 2. Fentanyl 7 mcg IV q1 prn 3. Versed 1.2mg IV q1 prn **Neuro - Assessment & Plan:** subdural hematoma, NAT 1. neurosurgery following-> no CTs needed, 2. neurology following-> continuous EEG, d/c Keppra and Fosphenytoin, PB level 4/24 burst suppression for 24hr c versed drip goal PB level 30's
CVS. 4/22 occasional bradycardia lasting few seconds HR 120-150 BP: 70s 90's / 45-65 **Exam:** CTAB ϕ stridor noted	1. **CVS - Assessment & Plan:** stable 1. monitor for bradycardia (? Possibly secondary to inc ICP) 2.
Pulmonary. intubated 4/20- 4/21, stridor immediately post extubation and received Racemic Epi, 4/23 HHNC due to apnea + resp distress HHNC 8 L FiO2 50% RR: 30-45 Sats: wean to **Exam:** RRR SLS 2ϕM 2+ femoral pulses **CXR:** 4/23 peripheral airspace opacities	1. Racemic Epi 11.25mg inh q2 prn stridor 2. **Pulmonary - Assessment & Plan:** stridor post extubation, apnea s/p PB administration, on HHNC 1. Monitor for resp distress esp while seizing 2. May need intubation w/ versed drip
Infectious Disease Temp: Tm 100.4 **WBC:** **Cultures:** Blood cx 4/20 NGTD, urine cx 4/20 negative, sputum culture heavy growth staph aureus (pan sensitive) and strep pneumoniae	1. Tylenol 100mg prn po/pr q4 fever **Infectious Disease - Assessment & Plan:** 1. follow up blood culture 2.
Heme: SDH stable 	1. 2. **Heme – Assessment & Plan:** SDH s/p NAT 1. no active bleeding
FEN/GI: 4/21 OG removed, advanced feeds, on 4/22 NPO, MIVF, 4/23 NS bolus, ND placement and start feeds IN/OUT: 420/465 Balance: -45cc UOP: 2-8 mL/kg/hr BM/Emesis: ϕ Diet: Similac 20cal/oz ND 30cc/hr repeat UA 4/22 negative KUB ND in place Exam: SOFT NTND MABS ϕ Masses  	1. ~~D5 NS @ 2 cc/hr~~ 4L IV **FEN/GI - Assessment & Plan:** enteric feeds started 4/23 1. Similac feeds at 30cc/hr (70 cal/kg/day = 106 cc/kg/day) 2. 4/24 AM labs: CMP 3. Monitor if stools today (ϕ yesterday) may give Glycerin suppository
Social: CPS called from ED, homicide detective involved (confession from baby sitter who shook baby), social work + Dr. Hauda involved, Dr. Kronen consulted for mom **PMR:** Speech: reassess when taking po, PT/OT recs: extensive therapy	**Assesment & Plan:** NAT 1. skeletal survey 4/22 negative for fractures 2. per FACT team, needs May 1st repeat skeletal survey (inpt/outpt)

Susan Mabrouk

Susan Mabrouk, M.D., P13755
4/24/2009 7:38 AM

MED0545

Pediatric ICU Attending Note
4/24/09 Time: 1000

W[redacted] N[redacted] G
MRN 4305493
DOB: [redacted]08

ID: 4.5 mo. male admitted with seizure, SDH, retinal hemorrhages c/w NAI with status epilepticus
Interim history: 4 clinical seizures yesterday with more than that seen on EEG. Phenobarb boluses and level 48 this a.m. Pt. responsive and moving all extr. Tolerated ND feeds. Stable on HHNC.

Images reviewed= none
Labs: per HPI and resident note
Numeric details per resident note.

PE:
AF- full, Pupils- reactive bilat., HHNC in place at time of exam.
RRR –m/r/g Lungs- clear, no distress, symmetric chest wall movement, -flaring, - retr
Abd- soft, NT, ND +BS
Extr- warm, 2+ pulses, CRT < 2 sec. No deformities.
Skin- no bruising.
Neuro- baseline seems somewhat flexed, moving all extr and vocalizing today.

A/P: 4.5 mo. male with SDH, bilateral retinal hemorrhages consistent with NAI. With status epilepticus--cont. EEG in progress. Given continued intermitten seizures (both clinical and sub-clinical) intubate and start versed infusion. Cont phenobarb with goal level in 25-30s.

- Neuro- Cont. EEG. Phenobarb BID. Follow levels. Start Versed drip and titrate to burst suppression. Will need MRI when stable. PT/OT/Speech involved.
- CV- stable
- Resp- Intubate to protect airway given side effects of AED treatment.
- GI- Restart feeds after intubation.
- Heme- stable.
- Dr. Houda consulted and involved. Skeletal survey negative, ? right wrist abnl. Repeat skeletal survey around May 1st.
- Social- Both mom and dad and extended family updated. Psych/SW/Case Mgt involved.

Swati Agarwal, MD Pager 13742

11:47:35 AM, 4/24/2009

Pediatric Critical Care
Intubation Note

This Patient was intubated with a 3.5 cuffed endotracheal tube.
The technique was performed using a routine intubation technique.
A Miller blade was used to facilitate the intubation.
The CXR showed that ETT is in Good Position.
Risks, benefits and alternatives were given to the family/guardian.
The intubation was confirmed by presence of CO2.

Indication(s) for the intubation
Airway Protection

Anesthestics Used
Atropine
Fentanyl
Midazolam
Vecuronium

Initial Ventilator Settings:

Vt: NA	Rate: NA	PEEP: NA	FiO2: NA	PIP: NA

Additional Notes:
intubation performed by Dr. Mabrouk under my direct and constant supervision

Cynthia Gibson, M.D.

[redacted]430-54-93
W[redacted]
N[redacted] G [redacted]/08
04305493 4M M FH 37373672
PADM ADM ACCT STRT

INOVA FAIRFAX HOSPITAL FOR CHILDREN

1PN

Date & Time	ALL ENTRIES	PHYSICIAN signature includes complete Name and ID#

DATE | TIME

Procedure Note

4/24/08 1145AM Intubation @ 1130AM with ETT 3.5, cuffed. Prior to procedure, Fentanyl 14 mcg, Versed 7mg, and Atropine 0.1mg IV given and bagged for 2-3 min. Pancuronium given 0.8mg IV and bagged 1-2 min. With laryngoscope Miller 1 visualized NP tube and vocal cords and placed ETT past vocal cords without much resistance. ETCO2 was reading 30's and condensation on ETT as well as chest rise. +Oxsed BS, removed ETT slightly to 12 cm, taped at lip. Vent started and VC PSO, BS equal b/l and chest rise symmetrical. CXR ordered STAT to assess placement. Dr. Gibson bedside

Susannah Mabrouk
#5755

4/24/08 1525 Nutrition

D: Diet: Similac 20 + 30 cc/hr = 70 Kcals/kg
Ht: 65 cm (62nd %) Wt: 6.8 kg (39th %) wt/ht: 18th %
Labs: Alb - 3.0 ↓ (4/24) Meds/IVF reviewed.

A/P: Pt has been Tolerating feedings. Currently feeds on hold 2° intubation. Once feeds resumed suggest + MS considers + goal to 40 cc/hr = 94 Kcals/kg (as tolerated). Will follow prn.

Glaeser-Roman, RD, CSD
#73544

DO NOT USE
U
QD
qd
IU
mcg
QOD
QID/qid
AU
AS
AD
MS
MSO4
MgSO4
AZT
Nitro drip

PATIENT IDENTIFICATION

W[redacted] G[redacted]08
N[redacted]
04305493 4M M FH 37373672
PADM ADM ACCT STRT

INOVA HEALTH SYSTEM
PATIENT PROGRESS NOTES

CAT # 84797A / R102408
IHS-MS-PROG

MED0548

Pediatric ICU Attending Note
4/25/09 Time: 1200

W[redacted]N[redacted]G
MRN 4305493
DOB[redacted]08

ID: 4.5 mo. male admitted with seizure, SDH, retinal hemorrhages c/w NAI with status epilepticus
Interim history: Intubated and started on Versed infusion yesterday to control seizures. Electrographic seizures on EEG and awakening therefore Pentobarb 2 mg/kg x 3 overnight. No seizures since 8 p.m. Sedated this a.m. Occ. Awakening per nursing. Req'd fluid bolus overnight for low BP. Phenobarb level 48 today

Images reviewed= ETT ok, perihilar haziness, no focal infiltrate
Labs: per HPI and resident note
Numeric details per resident note.

PE:
AF- hard to assess given EEG leads and cap, Pupils- small and reactive bilat., intubated
RRR –m/r/g Lungs- clear, no distress, symmetric chest wall movement, -flaring, - retr
Abd- soft, NT, ND +BS
Extr- warm, 2+ pulses, CRT < 2 sec. No deformities.
Skin- no bruising.
Neuro- baseline seems somewhat flexed, moving all extr when awake

A/P: 4.5 mo. male with SDH, bilateral retinal hemorrhages consistent with NAI. With status epilepticus-- cont. EEG in progress. No sz on EEG since 8 p.m.

- Neuro- Cont. EEG. Phenobarb BID. Follow levels. Cont Versed drip at 5 mg/hr. Pentobarb prn, EEG appears mostly suppressed. Will need MRI when stable. PT/OT/Speech involved.
- CV- stable. Dopamine drip available.
- Resp- Stable on vent. Adjust to keep ETCO2 35-45
- GI- Incr feeds ND
- Heme- No issues.
- Dr. Houda consulted and involved. Skeletal survey negative, ? right wrist abnl. Repeat skeletal survey around May 1st.
- Social- Both mom and dad and extended family updated. Psych/SW/Case Mgt involved.

Swati Agarwal, MD Pager 13742

PICU Resident Progress Note

Saturday, April 25, 2009

Name: W[redacted] N[redacted] Room: 501 Age: 4.5 months
DOB[redacted]2008 MRN: 4305493 Admit Date: 4/20/2009
Wt: 6.8kg PICU admit: 4/20/2009

Problem List:
1. subdural hematoma
2. b/l retinal hemorrhages
3. NAT
4. status epilepticus

Allergies: NKDA , NKFA

Lines/Tubes/Drains:
1. PIV
2. ND
3. ETT, 3.5 cuffed

Neuro: optho c/s showed retinal hemorrhages, neuro c/s EEG and dilantin level, 4/22 R sided focal clonic movements, 4/23 generalized sz

Exam: decreased tone, drowsy, pinpoint pupils, ~~decreased mvt of R side -> L~~ sedated

4/22 CT head stable SDH
4/23 Phenobarbital 25 (nl) -> 30
4/24 Phenobarbital 48
4/25 PB lvl 48

1. Phenobarbital 10mg IV q12
2. Versed IV 5mg/hr
3. Fentanyl 7-14 mcg IV q1 prn → 1 bolus 20 mcg
4. Versed 2mg IV q1 prn
5. Ativan 0.7mg IV q1 prn
6. Pentobarbital x3 doses given

Neuro - Assessment & Plan: subdural hematoma, NAT
1. neurosurgery following-> no CTs needed,
2. neurology following-> continuous EEG, burst suppression with versed drip, goal PB level 35-45, Fentanyl drip 1 bolus

CVS. 4/22 occasional bradycardia lasting few seconds 4/24 hypotensive with versed drip x2 NS boluses
HR BP:

Exam: unchanged

1.
CVS - Assessment & Plan: stable
1. Dopamine gtt ordered (RN to call) for persistent hypotension
2.

Pulmonary. intubated 4/20- 4/21, stridor immediately post extubation and received Racemic Epi, 4/23 HHNC due to apnea + resp distress

Mode: PRVC **PC:** 70 cc **R:** **FiO2:** wean to keep sats >92%
PEEP: **PS:**
RR: Sats:

Exam:

CXR: 4/25

1. Racemic Epi 11.25mg inh q2 prn stridor
2.

Pulmonary - Assessment & Plan: stridor post extubation, apnea s/p PB administration, intubated 4/24 for protecting airway
1. CXR qAM while intubated
2. CBG prn
3. keep ETCO2 in 30-50

Infectious Disease
Temp:

WBC:

Cultures: Blood cx 4/20 NGTD, urine cx 4/20 negative, sputum culture heavy growth staph aureus (pan sensitive) and strep pneumoniae

1. Tylenol 100mg prn po/pr q4 fever

Infectious Disease - Assessment & Plan:
1. follow up blood culture
2.

Heme: SDH stable

1.
2.
Heme – Assessment & Plan: SDH s/p NAT
1. no active bleeding

FEN/GI: 4/21 OG removed, advanced feeds, on 4/22 NPO, MIVF, 4/23 NS bolus, ND placement and start feeds

IN/OUT: Balance:
UOP: mL/kg/hr BM/Emesis:
Diet: Similac 20cal/oz ND 30cc/hr
KUB 4/23 ND in place

Exam:

1. HLIV

FEN/GI - Assessment & Plan: enteric feeds started 4/23
1. Similac feeds at 30cc/hr (70 cal/kg/day = 106 cc/kg/day)
2. nutrition recommended increasing feeds to 40cc/hr (94cal/kg/day)

Social: CPS called from ED, homicide detective involved (confession from baby sitter who shook baby), social work + Dr. Hauda involved, Dr. Kronen consulted for mom's anxiety

PMR: Speech: reassess when taking po, PT/OT recs: extensive therapy

Assesment & Plan: NAT
1. skeletal survey 4/22 negative for fractures
2. per FACT team, needs May 1st repeat skeletal survey (inpt/outpt)

Susan Mabrouk, M.D., P1375
4/25/2009 8:03 AM

1PN

Date & Time	ALL ENTRIES — PHYSICIAN signature includes complete Name and ID#
DATE	TIME

4/24 — c EEG -

Generalized slowing of background.
There are frequent sequences c periodic lateralized spikes & polyspikes, often i generalized distribution, sometimes more prominent laterally, often more prominent in the (R), seizure last many minutes

4/25/09 8[illegible] AM — Video EEG checked - working well
Dolly A Hines REEGT

4/25/09 9[illegible] AM — Neuro -
Last clinical sz last pm ~ 8[illegible] pentobarb begun — on top of plano & doses of versed.
No further clinical sz since addition of pentobarb.
Continuous scalp shows diffuse low voltage c some bilateral centroparietal slowing & epileptiform activity.
Would continue meds the same & if all stable in the AM - w/o any clinical sz, then try to wean back in the AM.
Discussed c mother, grandfather & PICU staff
T Watkin - 8[illegible]2008

DO NOT USE
U
QD
qd
IU
µg
QOD
QID/qid
AU
AS
AD
MS
MS04
MgSO4
AZT
Nitro drip

PATIENT IDENTIFICATION

W[redacted]
N[redacted]
G[redacted]08
04305493 4M M FH 37373672
PADM ADM ACCT STRT

INOVA HEALTH SYSTEM
PATIENT PROGRESS NOTES

CAT # 84797A / R102408
IHS-MS-PROG

MED0551

1PN

Date & Time	ALL ENTRIES	PHYSICIAN signature includes complete Name and ID#
DATE	TIME	
4/2?		C-EEG
		Generalized slow bkg ē more complex waveforms now.
		Starting to differentiate wake/sleep
		Occasional bursts of slow activity
		L>R –
		but improved from yesterday.
		[signature]
4-26-09	9:15 AM	Neuro
		d/ Sz – continuous EEG shows diffuse low voltage – Reported previous 24 hrs showed the same with rare EFD'S – much improved from the previous 24hrs
		At this pt I would suggest slowing weaning off the versed. Continue the phenobarb. If he has some Sz like activity → begin Keppra – 20 mg/kg IV 1st dose & then 10mg/kg IV BID.
		T Watkins
		8f200

DO NOT USE: U, QD, qd, IU, μg, QOD, QID/qid, AU, AS, AD, MS, MS04, MgSO4, AZT, Nitro drip

PATIENT IDENTIFICATION

W[redacted]
N
G[redacted]08
04305493 4M M FH 37373672
PADM ADM 04/20/09 ACCT STRT

INOVA HEALTH SYSTEM
PATIENT PROGRESS NOTES

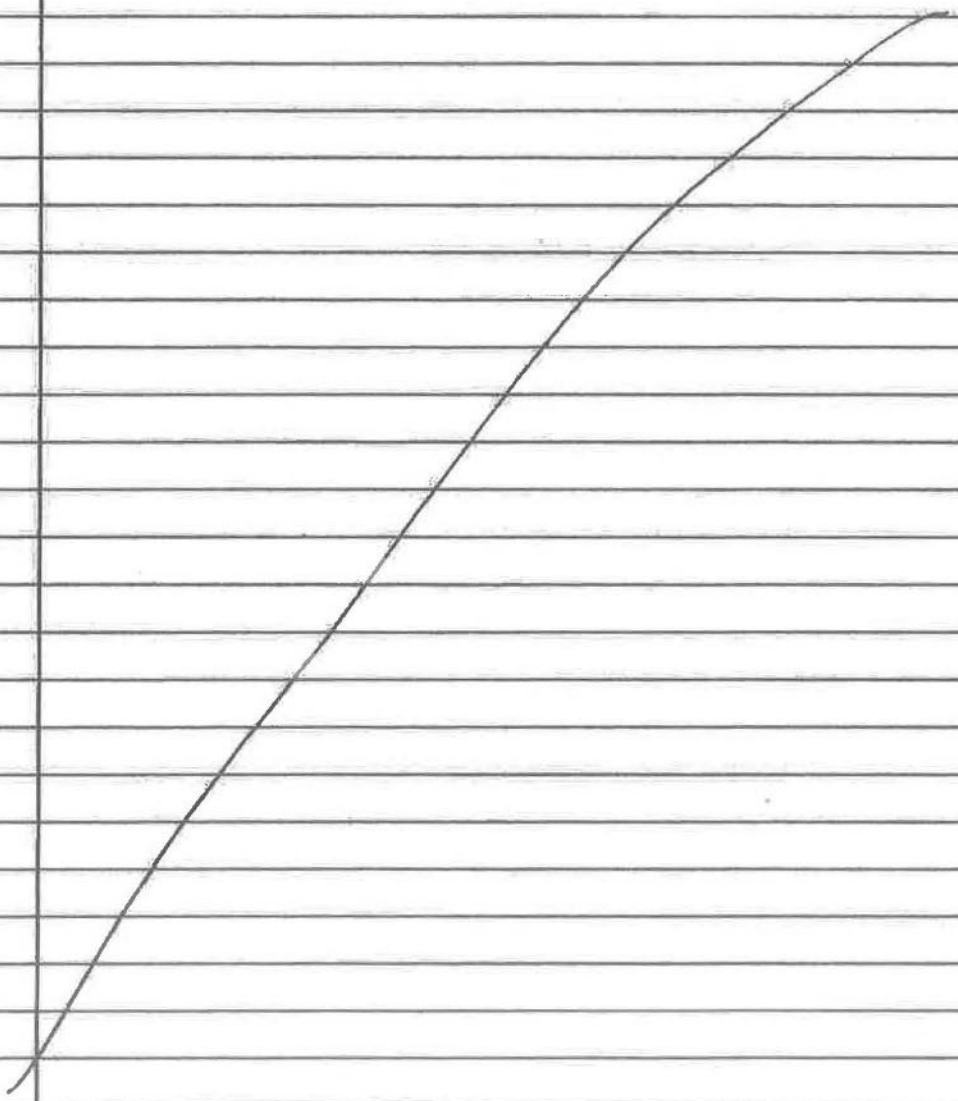
CAT # 84797A / R102408
IHS-MS-PROG

MED0552

1PN

Date & Time	ALL ENTRIES	PHYSICIAN signature includes complete Name and ID#

DATE	TIME	
4/26/09	10[illegible]	Video EEG checked - working well Dr. [illegible] Attn. EEG



DO NOT USE

U
QD
qd
IU
µg
QOD
QID/qid
AU
AS
AD

MS
MS04
MgSO4
AZT

Nitro drip

W [redacted]
N [redacted] G [redacted] 08
04305493 4M M FH 37373672
PADM ADM 04/20/09 ACCT STRT

INOVA HEALTH SYSTEM
PATIENT PROGRESS NOTES

CAT # 84797A / R102408
IHS-MS PROG

MED0553

Pediatric ICU Attending Note
4/26/09 Time: 1400

W[redacted], N[redacted]G
MRN 4305493
DOB: [redacted]08

ID: 4.5 mo. male admitted with seizure, SDH, retinal hemorrhages c/w NAI with status epilepticus
Interim history: No seizures since 8 p.m. on 4/24/09. Sedated this a.m. Occ. Awakening per nursing. Hemodynamics stable. Phenobarb level 45 today. Tm 101.3

Images reviewed= ETT ok, perihilar haziness, no focal infiltrate
Labs: per HPI and resident note. WBC 11 Hct 27 Plt 230, Sputum with rare WBC
Numeric details per resident note.

PE:
AF- hard to assess given EEG leads and cap, Pupils- small and reactive bilat., intubated
RRR –m/r/g Lungs- clear, no distress, symmetric chest wall movement, -flaring, - retr
Abd- soft, NT, ND +BS
Extr- warm, 2+ pulses, CRT < 2 sec. No deformities.
Skin- no bruising.
Neuro- moving all extr when awake

A/P: 4.5 mo. male with SDH, bilateral retinal hemorrhages consistent with NAI. With status epilepticus--cont. EEG in progress. No sz on EEG since 8 p.m. on 4/24/09. Will start to wean Versed drip and if breakthrough sz, use Keppra per Neuro recs. Cont phenobarb.

- Neuro- Cont. EEG. Phenobarb BID. Follow levels. Versed drip at 5 mg/hr→wean. EEG appears mostly suppressed. Will need MRI when stable. Will use Keppra if sz. PT/OT/Speech involved. On Fentanyl drip. Add Chloral Hydrate.
- CV- stable.
- Resp- Stable on PRVC. Adjust to keep ETCO2 35-45
- GI- On feeds ND
- Heme- No issues.
- ID- low grade temp. No abx for now. No deep lines.
- Dr. Houda consulted and involved. Skeletal survey negative, ? right wrist abnl. Repeat skeletal survey around May 1st. Recommend ophtho to re-examine around May 4th.
- Social- Both mom and dad and extended family updated. Psych/SW/Case Mgt involved.

Swati Agarwal, MD Pager 13742

PICU Resident Progress Note

Sunday, April 26, 2009

Name: W[redacted] N[redacted] Room: 501 Age: 4.5 months
DOB: [redacted]2008 MRN: 4305493 Admit Date: 4/20/2009
Wt: 6.8kg PICU admit: 4/20/2009

Problem List: 1. subdural hematoma 2. b/l retinal hemorrhages 3. NAT 4. status epilepticus	**Allergies**: NKDA , NKFA **Lines/Tubes/Drains:** 1. PIV 2. ND 3. ETT, 3.5 cuffed
Neuro: optho c/s showed retinal hemorrhages, neuro c/s EEG and dilantin level, 4/22 R sided focal clonic movements, 4/23 generalized sz, Pentobarbital on 4/24 given x3 **Exam:** decreased tone, drowsy, pinpoint pupils, decreased mvt of R side > L 4/22 CT head stable SDH 4/23 Phenobarbital 25 (nl) -> 30 4/24 Phenobarbital 48 4/25 Phenobarbital 48 4/26 Phenobarbital 45	1. Phenobarbital 10mg IV q12 2. Fentanyl 10mcg/hr 3. Versed IV 5mg/hr 4. Fentanyl 20 mcg IV q1 prn 5. Versed 3mg IV q1 prn 6. Ativan 0.7mg IV q1 prn **Neuro - Assessment & Plan:** subdural hematoma, NAT 1. neurosurgery following-> no CTs needed, 2. Will need to obtain MRI when stable 3. Will begin Chloral hydrate 175mg ND q6h 4. Will decrease Versed drip by 1mg/h q12h 5. Will obtain daily Phenobarbital levels, keep 35-45
CVS. 4/22 occasional bradycardia lasting few seconds 4/24 hypotensive with versed drip x2 NS boluses HR BP: **Exam:**	1. **CVS - Assessment & Plan:** stable 1. Dopamine gtt ordered (RN to call) for persistent hypotension 2.
Pulmonary. Intubated 4/20- 4/21, stridor immediately post extubation and received Racemic Epi, 4/23 HHNC due to apnea + resp distress **Mode:** PRVC TV: 70 R 35 FIO_2: 30% PEEP 5 RR: 25-30 Sats: 96-100% PIP: 17-19 $EtCO_2$: 29-34 **Exam:** CTA b/l no wheezes, rales or rhonchi **CXR: 4/26** Clear	1. Racemic Epi 11.25mg inh q2 prn stridor 2. **Pulmonary - Assessment & Plan:** stridor post extubation, apnea s/p PB administration, intubated 4/24 for protecting airway 1. CXR qAM while intubated 2. CBG prn 3. maintain ETCO2 in 30s
Infectious Disease Tm: 101.3 (12a) **WBC: 11.2** Cultures: Blood cx 4/20 NGTD, urine cx 4/20 negative, sputum culture heavy growth staph aureus (pan sensitive) and strep pneumoniae 4/26 BCX pending 4/26 sputurm cx pending	1. Tylenol 100mg prn po/pr q4 fever **Infectious Disease - Assessment & Plan:** 1. Will continue to monitor 2. Will follow cultures
Heme: SDH stable 	1. **Heme – Assessment & Plan:** SDH s/p NAT 1. no active bleeding 2. Will continue to monitor
FEN/GI: 4/21 OG removed, advanced feeds, on 4/22 NPO, MIVF, 4/23 NS bolus, ND placement and start feeds IN/OUT: 1064/758 Balance: +306 UOP: 4.6 mL/kg/hr BM/Emesis: Diet: Similac 20cal/oz ND 40cc/hr IVF: NS @4ml/h KUB 4/23 ND in place **Exam:**	1. HLIV **FEN/GI - Assessment & Plan:** enteric feeds started 4/23 1. Similac feeds at 40cc/hr (94 cal/kg/day) 2. Continue Similac 40cc/hr ND (94cal/kg/day)
Social: CPS called from ED, homicide detective involved (confession from baby sitter who shook baby), social work + Dr. Hauda involved, Dr. Kronen consulted for mom's anxiety	**Assesment & Plan:** NAT 1. skeletal survey 4/22 negative for fractures 2. per FACT team, needs May 1st repeat skeletal survey (inpt/outpt)

Susan Mabrouk, M.D., P13755
4/26/2009 6:47 PM

PICU Resident Progress Note

Sunday, April 26, 2009

Name: W[redacted] N[redacted]
DOB: [redacted]2008
Wt: 6.8kg

Room: 501
MRN: 4305493

Age: 4.5 months
Admit Date: 4/20/2009
PICU admit: 4/20/2009

PMR: Speech: reassess when taking po, PT/OT recs: extensive therapy	

Silvia E Backus

Susan Mabrouk, M.D., P13755
4/26/2009 6:47 PM

1PN

Date & Time		ALL ENTRIES — PHYSICIAN signature includes complete Name and ID#
DATE	TIME	Neurology Att Note — Dr [illegible]
4/27/09		Pt seen & examined s/p rec'd from [illegible]
		Chart rd Images personally reviewed.
		Pt suffered NAT 1 week ago w/
		subacute subdural hematoma, retinal
		hemorrhages d/c'd
		Placed on VEEG after facing Phenobarb
		Current Phenobarb level is 39 on VEEG
		EEG: diffusely slow & encephalopathic
		no SZ activity seen.
		Exam: Sedated, intubated, Phenobarb
		does not withdraw from
		noxious stim B/L L>R.
		min spont movt of upper
		ext. (R) hyperreflexia
		noted
		Plan: Wean VEEG if SZ
		occurs pls use push button
		Load 20mg/kg IV Keppra
		& start 10 mg/kg/d BID
		maint
		- Close neuro monitoring.
		- Cont Phenobarb
		[signature]

DO NOT USE: U, QD, qd, IU, μg, QOD, QID/qid, AU, AS, AD, MS, MS04, MgSO4, AZT, Nitro drip

PATIENT IDENTIFICATION

[redacted]
04305493 4 m M FH 37373672
PADM ADM
G [redacted] 2008
ACCT STRT 4/20/2009

INOVA HEALTH SYSTEM
PATIENT PROGRESS NOTES

CAT # 84797A / R102408
IHS-MS-PROG

MED0557

1PN

Date & Time		ALL ENTRIES — PHYSICIAN signature includes complete Name and ID#
DATE	TIME	
4/27/09	1511	PICU STAFF
		Pt 57 - weane weaning ~~the~~ the
		VERSED - now down to 2 mg/hr
		PBARB level 39
		Also on Fentanyl prn
		lungs clear - moderate vent settings
		PRVC 70 x 28 ft 36% - good sats
		RRR s̄ (murmur) good pulses + perfusion
		Abd soft (+) Bowel Sounds -
		Feeds going well ND
		Intermittently febrile (now 99.9°) -
		No (+) Cultures
		[signature] 7830 Futterman
4/27/09	4:00PM	EEG
		No seizures seen. Background 3Hz - asymmetric vertex
		waves over left. Not as well seen compared to right.
		Sleep spindles present - less over left fronto/central.
		occasional sharps F4, P4, P3 - right fronto parietal, left parietal.
		Ø seizures. Predominantly during sleep - or arousal.
		S. Dazet Altavenuro 703-845-1500

DO NOT USE: U, QD, qd, IU, µg, QOD, QID/qid, AU, AS, AD, MS, MSO4, MgSO4, AZT, Nitro drip

PATIENT IDENTIFICATION

W[redacted]
N[redacted]
G[redacted]2008
04305493 4 m M FH 37373672
PADM ADM ACCT STRT 4/20/2009

INOVA HEALTH SYSTEM

PATIENT PROGRESS NOTES

CAT # 84797A / R102408

IHS-MS-PROG

MED0558

PICU Resident Progress Note

Monday, April 27, 2009

Name: W[redacted] N[redacted] Room: 501 Age: 5 months
DOB: [redacted]9/2008 MRN: 4305493 Admit Date: 4/20/2009
Wt: 6.8kg PICU admit: 4/20/2009

Problem List:
1. subdural hematoma
2. b/l retinal hemorrhages
3. NAT
4. status epilepticus

Allergies: NKDA , NKFA

Lines/Tubes/Drains: 2 PIV, ND, ETT, 3.5 cuffed

Neuro: optho c/s showed retinal hemorrhages, neuro c/s EEG and dilantin level, 4/22 R sided focal clonic movements, 4/23 generalized sz continuous EEG, Pentobarbital on 4/24 given x3, 4/26 wean Versed

Exam: decreased tone, sedated, pinpoint pupils, decreased mvt of R side > L

4/22 CT head stable SDH

Date	Phenobarbital lvl	Date	Phenobarbital lvl
4/23	25	4/27	39
4/24 +25	48, 48	4/28	
4/26	45	4/29	

1. Phenobarbital 10mg IV q12
2. Fentanyl 10mcg/hr
3. Versed IV 2mg/hr
4. Chloral hydrate 210mg ND q6
5. Fentanyl 27 mcg IV q1 prn
6. Versed 3mg IV q1 prn
7. Ativan 0.7mg IV q1 prn

Neuro - Assessment & Plan: subdural hematoma, NAT
1. neurosurgery following-> no CTs needed,
2. Will need to obtain MRI when stable
3. Will decrease Versed drip by 1mg/h q12h
4. Will obtain daily Phenobarbital levels, keep 35-45

CVS. 4/22 occasional bradycardia lasting few seconds 4/24 hypotensive with versed drip x2 NS boluses
HR BP:

Exam: RRR S1S2 0M 2+ pulses

1.
CVS - Assessment & Plan: stable
1. Dopamine gtt ordered (RN to call) for persistent hypotension.
2. try bolus with NS if hypotensive

Pulmonary. Intubated 4/20- 4/21, stridor immediately post extubation and received Racemic Epi, 4/23 HHNC due to apnea + resp distress

Mode: PRVC TV: 70 R 28 FIO_2: 36% PEEP 5
RR: Sats: PIP: $EtCO_2$:

Exam: CTA b/l no wheezes, rales or rhonchi

CXR: 4/27 improved pulmonary edema

1. Racemic Epi 11.25mg inh q2 prn stridor
2.

Pulmonary - Assessment & Plan: stridor post extubation, apnea s/p PB administration, intubated 4/24 for protecting airway
1. CXR qAM while intubated
2. CBG pm
3. maintain ETCO2 in 30s
4. pull ETT back 1 cm today, plan to extubated tomorrow 4/28

Infectious Disease
Tm:
~~WBC:~~

Cultures: Blood cx 4/20 NGTD, urine cx 4/20 negative, sputum culture heavy growth staph aureus (pan sensitive) and strep pneumoniae
4/26 BCX pending
4/26 sputum cx pending

1. Tylenol 100mg prn po/pr q4 fever

Infectious Disease - Assessment & Plan:
1. Will continue to monitor
2. Will follow cultures

Heme: SDH stable

1.
Heme – Assessment & Plan: SDH s/p NAT
1. no active bleeding
2. Will continue to monitor

FEN/GI: 4/21 OG removed, advanced feeds, on 4/22 NPO, MIVF, 4/23 NS bolus, ND placement and start feeds

IN/OUT: 1064/758 Balance: +306
UOP: 4.6 mL/kg/hr BM/Emesis:
Diet: Similac 20cal/oz ND 40cc/hr (94 cal/kg/day)
IVF: NS @4ml/h

Exam: SOFT NT ND NABS

Mycelin suspension 0.5 tab PR q24 pm

FEN/GI - Assessment & Plan: enteric feeds started 4/23
1. Continue Similac 40cc/hr ND (94cal/kg/day)

FACT: CPS called from ED, homicide detective involved (confession from baby sitter who shook baby), social work + Dr. Hauda involved, Dr. Kronen consulted for mom's anxiety. skeletal survey 4/22 negative for fractures
PMR: Speech: reassess when taking po, PT/OT recs: extensive therapy

Assessment & Plan: NAT
1. per FACT team, needs May 1st repeat skeletal survey (inpt/outpt)

☐ Monitor for seizures

Susan Mabrouk, M.D., P13755
4/27/2009 3:46 PM

1PN

Date & Time	ALL ENTRIES	PHYSICIAN signature includes complete Name and ID#
DATE	TIME	Neurology Att Note
4/28/09		Pt seen & examined. Vised gtt being weaned
		& clinical SZ reported
		EEG reviewed for last 2° (could not do
		more 2° computer issues). No electrographic
		SZ seen
		Pt more awake today briefly opens
		eyes
		PERRL EOMI
		min spont. movt, but more forceful
		withdrawal
		Plan - cont to wean versed gtt.
		plan to treat w/ IV keppra
		(as per my note) if SZ
		recur
		cont phenobarbital @ current
		dose
		[signature]
1426 4/28/09		PICU STAFF
		On Fent + chloral hydrate prn
		Versed drip ↓ to [illegible] & will be off in
		30 minutes. No evidence of SZ activity
		Also on PBARB -
		On rate = 20 on vent ETCO2 38-42 - not
		breathing over vent lungs clear to auscultation
		RRR ⓪ good pulses + perfusion
		Abd soft ⊕ Bowel sounds - Feeds going
		well - Hct ↓ to 22%
		Now afebrile No ⊕ Cx's - other than sputum
		repeat sputum pending
		[signature] 1330

DO NOT USE: U, QD, qd, IU, µg, QOD, QID/qid, AU, AS, AD, MS, MSO4, MgSO4, AZT, Nitro drip

PATIENT IDENTIFICATION

W[redacted]
N[redacted]
04305493 4 m M FH 37373672
PADM ADM
G[redacted]2008
ACCT STRT 4/20/2009

INOVA HEALTH SYSTEM [signature]
PATIENT PROGRESS NOTES

CAT # 84797A / R102408

PICU Resident Progress Note

Wednesday, April 29, 2009

Name: W[redacted], N[redacted] Room: 501 Age: 5 months
DOB: [redacted]2008 MRN: 4305493 Admit Date: 4/20/2009
Wt: 6.8kg PICU admit: 4/20/2009

Problem List:
1. subdural hematoma
2. b/l retinal hemorrhages
3. NAT
4. status epilepticus

Allergies: NKDA , NKFA

Lines/Tubes/Drains: 2 PIV, ND, ETT, 3.5 cuffed

Neuro: optho c/s showed retinal hemorrhages, neuro c/s EEG and dilantin level, 4/22 R sided focal clonic movements, 4/23 generalized sz continuous EEG, Pentobarbital on 4/24 given x3, 4/26-28 Versed drip

Exam: decreased tone, sedated, pinpoint pupils, decreased mvt of R side > L

4/22 CT head stable SDH

date	PB level
26-Apr	45
27-Apr	39
28-Apr	33
29-Apr	35

1. Phenobarbital 10mg IV q12
2. Fentanyl 20mcg/hr (↑ from 10 mcg/hr)
3. Chloral hydrate 270mg ND q6 (↑ from 210 mg)
4. Fentanyl 27 mcg IV q1 prn x 8
5. Ativan 0.7mg IV q1 prn

Neuro - Assessment & Plan: subdural hematoma, status epilepticus
1. neurosurgery following-> no CTs needed
2. neuro recs: EEG for 24 more hours to r/o subclinical seizures, **If seizures recur 20mg/kg IV Keppra, then 10mg/kg/day DIV BID**
3. Will need to obtain MRI later date
4. Will obtain daily Phenobarbital levels, keep 35-45
5. After keppra load, can give Phenobarbital 5mg/kg/dose bolus if still seizing
6. in 2hrs DIC fentanyl drip, 5 decadron

CVS. 4/22 occasional bradycardia lasting few seconds 4/24 hypotensive with versed drip x2 NS boluses
HR 51-87 BP: 80-110) 40 50's

Exam:

1.
CVS - Assessment & Plan: stable
1. Dopamine gtt ordered (RN to call) for persistent hypotension
2. try bolus with NS if hypotensive

Pulmonary. intubated 4/20- 4/21, stridor immediately post extubation and received Racemic Epi, 4/23 HHNC due to apnea + resp distress

Mode: ~~PRVC~~ PSIMV TV: 70 R 28 FiO_2: 36% PEEP 5
RR: 28 Sats: 99-100% PIP: 18 $EtCO_2$: 35-49

Exam: CTA b/l no wheezes, rales or rhonchi

CXR: 4/27 improved pulmonary edema 4/29 noted pulm edema

1. Racemic Epi 11.25mg inh q2 prn stridor
2.
Pulmonary - Assessment & Plan: stridor post extubation, apnea s/p PB administration, intubated 4/24 for protecting airway
1. CXR qAM while intubated
2. CBG prn
3. maintain ETCO2 in 30s
4. wean rate for plan to extubate 4/29 → ~~HHNC~~ NC 20 L per 1 hr
5. Decadron one dose now 4mg IV

Infectious Disease
Tm: 102.5°
WBC: 10 4/28

Cultures: sputum culture heavy growth staph aureus (pan sensitive) and strep pneumoniae (pan sensitive)
4/26 BCX NGTD
4/26 sputum cx : staph aureus and strep pneumoniae
4/27 Blood cx NGTD

1. CTX 340mg IV q12 day 2/5
2. Tylenol 100mg prn po/pr q4 fever x 6

Infectious Disease - Assessment & Plan:
1. Will follow cultures
2. Treat for sputum MSSA and strep with CTX, monitor fevers

Heme: SDH stable
4/28 7.2
22

1.
Heme – Assessment & Plan: SDH s/p NAT, anemia
1. no active bleeding
2. Will continue to monitor
3. Start Fe ND

FEN/GI: 4/21 OG removed, advanced feeds, on 4/22 NPO, MIVF, 4/23 NS bolus, ND placement and start feeds

IN/OUT: 1033/1025 Balance +13 cc
UOP: 6.3 mL/kg/hr BM/Emesis: x6
Diet: Similac 20cal/oz ND 40cc/hr (94 cal/kg/day)
IVF: NS @4ml/h

Exam:

1. Glycerin suppository 0.5 tab pr q24 pm no stool

FEN/GI - Assessment & Plan: enteric feeds started 4/23
1. Continue Similac 40cc/hr ND (94cal/kg/day)
2. Loose stools developed 4/27

Susan Mabrouk, M.D., P13755
4/29/2009 12:37 AM

PICU RESIDENT TRANSFER SUMMARY, 4/30/09

Name: W[redacted], N[redacted] Room: 501 Age: 4.5 month

DOB: [redacted]2008 MRN: 4305493 PICU Admission Date: 4/20/2009

FEN/GI/Heme: NPO while intubated and started Pedialyte on 4/21 and advanced to Similac po ad lib. NPO while seizing on 4/22 with D5 NS at maintenance. On 4/23 ND placed and started goal feeds. 4/30 speech to reevaluate ability to feed po. Anemia on 4/28 H/H 7/22

Plan: currently Similiac 20cal/oz @ 40cc/hr ND, can pull to NG and/or start po feeds per Speech, continue Iron for anemia

PMR: Speech and PT/OT consulted on 4/22 to assess developmental status post injury. Requires extensive PT/OT. Speech to reassess when extubated 4/30.

Plan: outpatient Speech, PT/OT at IFHC required (parents aware)

FACT: Homicide detective was involved on DOA. CPS called from the ED and Police investigation obtained confession from babysitter who shook the baby. Dr. Hauda (child abuse team) was consulted 4/21 and recommended repeat skeletal survey on May 1st (inpatient or outpatient). Social work involved. Skeletal survey on 4/22 was negative for fracture. Dr. Kronen consulted because mom had anxiety and wasn't visiting Noah earlier on in PICU course. Parents are both currently at bedside and involved in care.

Plan: on May 1st repeat skeletal survey required, will need FACT team follow up as outpatient

All remaining systems stable.

Problem List:

1. subdural hematoma, stable
2. b/l retinal hemorrhages
3. NAT
4. status epilepticus
5. encephalopathy

Meds:

Phosphenytoin 20mg ND q12
Valium 0.5mg ND q6
Ceftriaxone 340mg IV q12 day 3/5
Iron Sulfate 15mg ND q12
Ativan 0.7mg IV q1 prn seizures
Tylenol 100mg pr/po q4 prn fever
Racemic epi 11.25mg q2 prn stridor

PHYSICAL EXAM:
See today's Progress Note

Consults: Neurology (Dr. Lateef), Neurosurgery (pager 61447), FACT Team (Dr. Hauda), PMR (Dr. Im)
Attending: Hospitalist, Futterman (ICU)
PMD: Kidz Docs

[redacted] G [redacted]08
04305493 5M M FH 37373672
PADM ADM ACCT STRT
04/20/09

Susan Mabrouk, M.D.
Pager 13755

1PN

Date & Time	ALL ENTRIES — PHYSICIAN signature includes complete Name and ID#
DATE / TIME	
5/1/09 2000	Nursing - #35 - Pt irritable at times today + sucked on pacifier vigorously. Quieter when Valium given + when feeds started. P- assess for pain. Pt to start Methadone tonight. Parents + many family members at bedside + very suspicious about tests. Pt had skeletal survey in am + MRI with anesthesia in pm. Parents tearful at times. Emotional support given. Kathy Funk RN
5/2/09 0715	Nursing Note Outcome 2 (S) Pts neuro VS show no Δ's throughout the shift. Pts VSS pt sleeping comfortably for most of the night. ø seizures. (P) Cont. to monitor neuro status Q4°; notify MD c any Δ's. Outcome 3 (S) Pt. rating ø on Flacc scale through the night. While awake pt. content c pacifier holding hands of family members. (P) Cont. to assess pain Q4° and PRN. Pts ND moved to NG - confirmed by KUB + feeds ↑ to 40mL/hr cont. at 2200 from 20mL/hr from 2000-2200. Pt. tol. well ø N/V. Will cont to monitor for vomiting. Lee A Knight RN

DO NOT USE
U
QD
qd
IU
µg
QOD
QID/qid
AU
AS
AD
MS
MSO4
MgSO4
AZT
Nitro drip

PATIENT IDENTIFICATION

W [redacted] G [redacted] 08
N [redacted]
04305493 5M M FH 37373672
PADM ADM 04/20/09 ACCT STRT

INOVA HEALTH SYSTEM
PATIENT PROGRESS NOTES

CAT # 84797A / R102408
IHS-MS-PROG

MED0585

1PO

DO NOT USE: U, IU, µg, QOD, QID, **QD/qd**, AU, AS, AD, MS, MSO4, MgSO4, AZT, Nitro drip

---

Date: 4/21/09
Time: 0130
Physician Signature

Printed Name / ID#
Susan Mabrouk, MD
ID # 13755
Pager # 13755

☐ Telephone Order
☐ Order read back & verified

RN / RT Signature

☐ Therapeutic interchange NOT permitted

Patient Weight: 6.8 kg ☑ actual ☐ ideal ☐ adjusted BSA: _____ m2
☐ DISCONTINUE ALL PREVIOUS ORDERS FOR THIS MEDICATION OR FLUID
MEDICATION OR FLUID: ceftriaxone
calculation (meds): ☑ 50 mg / kg / dose ☐ _____ / kg / day
☐ other: _____
DOSE: 340 ☐ grams ☑ mg ☐ mcg ☐ units ☐ other: _____
ROUTE: ☑ IV ☐ IM ☐ SC ☐ PO ☐ NG or GT ☐ ND ☐ PR ☐ Inhaled
☐ Other
FREQUENCY: ☑ every 24 hours ☐ _____ times a day ☑ 1 dose now
☐ every _____ hours, PRN: _____
☐ _____ mL/hr (fluid) ☐ other: _____
Medication concentration *(if indicated, e.g. digoxin)*: _____
Notes:

SCANNED TO PHARMACY
Date: 4/21/09
Time: 0215
RN Signature
#39
IDX order #
4/21/09 0300
Date/Time:
☐ 12 hour check
☑ 24 hour check

Date: 4/21/09
Time: 0345
Physician Signature

Susan Mabrouk, MD
ID # 13755
Pager # 13755

☐ Telephone Order
☐ Order read back & verified

RN / RT Signature

☐ Therapeutic interchange NOT permitted

Patient Weight: 6.8 kg ☑ actual ☐ ideal ☐ adjusted BSA: _____ m2
☐ DISCONTINUE ALL PREVIOUS ORDERS FOR THIS MEDICATION OR FLUID
MEDICATION OR FLUID: Versed
calculation (meds): ☑ 0.1 mg / kg / dose ☐ _____ / kg / day
☐ other: 0.2 mg SM errors
DOSE: 1.2 ☐ grams ☑ mg ☐ mcg ☐ units ☐ other: _____
ROUTE: ☑ IV ☐ IM ☐ SC ☐ PO ☐ NG or GT ☐ ND ☐ PR ☐ Inhaled
☐ Other
FREQUENCY: ☐ every _____ hours ☐ _____ times a day ☐ 1 dose now
☑ every 1 hours, PRN: agitation
☐ _____ mL/hr (fluid) ☐ other: _____
Medication concentration *(if indicated, e.g. digoxin)*: _____
Notes:

SCANNED TO PHARMACY
Date: 4/21/09
Time: 0400
RN Signature
#40
IDX order #
4/21/09 0330
Date/Time:
☐ 12 hour check
☑ 24 hour check

Date: _____
Time: _____
Physician Signature

Printed Name / ID#

☐ Telephone Order
☐ Order read back & verified

RN / RT Signature

☐ Therapeutic interchange NOT permitted

Patient Weight: 6.0 kg ☑ actual ☐ ideal ☐ adjusted BSA: _____ m2
☐ DISCONTINUE ALL PREVIOUS ORDERS FOR THIS MEDICATION OR FLUID
MEDICATION OR FLUID: fentanyl
calculation (meds): ☑ 1 mcg kg / dose ☐ _____ / kg / day
☐ other: errors SM
DOSE: 7 mcg errors SM ☐ grams ☐ mg ☑ mcg ☐ units ☐ other: _____
ROUTE: ☑ IV ☐ IM ☐ SC ☐ PO ☐ NG or GT ☐ ND ☐ PR ☐ Inhaled
☐ Other
FREQUENCY: ☐ every _____ hours ☐ _____ times a day ☑ 1 dose now
☑ every 1 hours, PRN: agitation
☐ _____ mL/hr (fluid) ☐ other: _____
Medication concentration *(if indicated, e.g. digoxin)*: _____
Notes:

SCANNED TO PHARMACY
Date: 4/21/09
Time: 0400
RN Signature
#41
IDX order #
4/21/09 0430
Date/Time:
☐ 12 hour check
☑ 24 hour check

W [redacted]
N [redacted]
04305493 PADM
4M ADM
M
G [redacted]08
FH 37373672 ACCT STRT

PATIENT IDENTIFICATION

INOVA FAIRFAX HOSPITAL FOR CHILDREN

PEDIATRIC MEDICATION ORDERS

CAT #85335 / R090908 • IFHC-PEDS-ORD • PKGS OF 100

MED0620

1PO

DO NOT USE: U, IU, µg, QOD, QID, **QD/qd**, AU, AS, AD, MS, MSO4, MgSO4, AZT, Nitro drip

Date: 4/28/09
Time: 1730
Physician Signature
Printed Name / ID#
Usan Mabrouk. MD
U # 13755
or # 13755
☐ Telephone Order
☐ Order read back & verified
RN / RT Signature
☐ Therapeutic Interchange NOT permitted

Patient Weight: 6-8 kg ☒ actual ☐ ideal ☐ adjusted BSA: _____ m2
☐ DISCONTINUE ALL PREVIOUS ORDERS FOR THIS MEDICATION OR FLUID
MEDICATION OR FLUID: Ceftriaxone
calculation (meds): ☒ 50mg / kg / dose ☐ _____ / kg / day
☐ other: _____
DOSE: 340 ☐ grams ☐ mg ☐ mcg ☐ units ☐ other: _____
ROUTE: ☒ IV ☐ IM ☐ SC ☐ PO ☐ NG or GT ☐ ND ☐ PR ☐ Inhaled
☐ Other
FREQUENCY: ☒ every 12 hours ☐ _____ times a day ☐ 1 dose now
☐ every _____ hours, PRN: _____
☐ _____ mL/hr (fluid) ☐ other: _____
Medication concentration *(if indicated, e.g. digoxin)*: _____
Notes:

SCANNED TO PHARMACY
Date: 4/28/09
Time: 1745 KA
Karen Clerk
RN Signature
#158
IDX order #
4/28/09 18
Date/Time:
☐ 12 hour check
☐ 24 hour check

Date: 4/28/09
Time: 2000
Physician Signature
Printed Name / ID#
A Mabrouk 13755
☐ Telephone Order
☐ Order read back & verified
RN / RT Signature
☐ Therapeutic Interchange NOT permitted

Patient Weight: 6.8 kg ☒ actual ☐ ideal ☐ adjusted BSA: _____ m2
☐ DISCONTINUE ALL PREVIOUS ORDERS FOR THIS MEDICATION OR FLUID
MEDICATION OR FLUID: Fentanyl
calculation (meds): ☐ _____ / kg / dose ☐ _____ / kg / day
☐ other: _____
DOSE: _____ ☐ grams ☐ mg ☐ mcg ☐ units ☐ other: _____
ROUTE: ☒ IV ☐ IM ☐ SC ☐ PO ☐ NG or GT ☐ ND ☐ PR ☐ Inhaled
☐ Other
FREQUENCY: ☐ every _____ hours ☐ _____ times a day ☐ 1 dose now
☐ every _____ hours, PRN: _____
☐ _____ mL/hr (fluid) ☒ other: 20mcg/hr
Medication concentration *(if indicated, e.g. digoxin)*: _____
Notes:

SCANNED TO PHARMACY
Date: 4-29-09 JO
Time: 00:15
RN Signature
IV
IDX order #
Date/Time:
☒ 12 hour check
☐ 24 hour check

Date: _____
Time: _____
Physician Signature
Printed Name / ID#
A Mabrouk 13755
☐ Telephone Order
☐ Order read back & verified
RN / RT Signature
☐ Therapeutic Interchange NOT permitted

Patient Weight: 6.8 kg ☒ actual ☐ ideal ☐ adjusted BSA: _____ m2
☐ DISCONTINUE ALL PREVIOUS ORDERS FOR THIS MEDICATION OR FLUID
MEDICATION OR FLUID: Chloral hydrate
calculation (meds): ☒ 40mg / kg / dose ☐ _____ / kg / day
☐ other: _____
DOSE: 270 ☐ grams ☒ mg ☐ mcg ☐ units ☐ other: _____
ROUTE: ☐ IV ☐ IM ☐ SC ☐ PO ☐ NG or GT ☒ ND ☐ PR ☐ Inhaled
☐ Other #155
FREQUENCY: ☐ every _____ hours ☐ _____ times a day ☐ 1 dose now
☒ every 6 hours, PRN: q6h prn
☐ _____ mL/hr (fluid) ☐ other: _____
Medication concentration *(if indicated, e.g. digoxin)*: _____
Notes: * will D/C to schedule

SCANNED TO PHARMACY
Date: 4-29-09 JO
Time: 00:15
RN Signature
144
IDX order #
Date/Time:
☐ 12 hour check
☐ 24 hour check

W [redacted] G [redacted] 08
N [redacted]
04305493 4M M FH 37373672
PADM ADM 04/20/09 ACCT STRT

INOVA FAIRFAX HOSPITAL FOR CHILDREN

PEDIATRIC MEDICATION ORDERS

CAT #85335 / R031409 • IFHC-PEDS-ORD • PKGS OF 100

MED0650

1PO

DO NOT USE: U, IU, µg, QOD, QID, **QD/qd**, AU, AS, AD, MS, MSO4, MgSO4, AZT, Nitro drip

---

Date: 5/1/09
Time: 2000

Physician Signature

Printed Name / ID#

☐ Telephone Order
☐ Order read back & verified

RN / RT Signature

☐ Therapeutic interchange NOT permitted

Patient Weight: 6.8 kg ☐ actual ☐ ideal ☐ adjusted BSA: ____ m2
☒ DISCONTINUE ALL PREVIOUS ORDERS FOR THIS MEDICATION OR FLUID
MEDICATION OR FLUID: Rectal Tylenol
calculation (meds): ☐ ________ / kg / dose ☐ ________ / kg / day
☐ other: ________
DOSE: ________ ☐ grams ☐ mg ☐ mcg ☐ units ☐ other: ________
ROUTE: ☐ IV ☐ IM ☐ SC ☐ PO ☐ NG or GT ☐ ND ☐ PR ☐ Inhaled
☐ Other ________
FREQUENCY: ☐ every ____ hours ☐ ____ times a day ☐ 1 dose now
☐ every ____ hours, PRN: ________
☐ ____ mL/hr (fluid) ☐ other: ________
Medication concentration *(if indicated, e.g. digoxin)*: ________
Notes:

SCANNED TO PHARMACY
Date: 5/1
Time: 2000
RN Signature DONE
IDX order #
Date/Time:
☒ 12 hour check
☒ 24 hour check 88

Date:
Time:

Meredith Lewis (signature)
Physician Signature

M. Carter
Printed Name / ID# 13205

☐ Telephone Order
☐ Order read back & verified

RN / RT Signature

☐ Therapeutic interchange NOT permitted

Patient Weight: 6.8 kg ☐ actual ☐ ideal ☐ adjusted BSA: ____ m2
☐ DISCONTINUE ALL PREVIOUS ORDERS FOR THIS MEDICATION OR FLUID
MEDICATION OR FLUID: Methadone
calculation (meds): ☒ 0.1 mg / kg / dose ☐ ________ / kg / day
☐ other: ________
DOSE: 0.7 ☐ grams ☒ mg ☐ mcg ☐ units ☐ other: ________
ROUTE: ☐ IV ☐ IM ☐ SC ☒ PO ☐ NG or GT ☐ ND ☐ PR ☐ Inhaled
☐ Other ________
FREQUENCY: ☒ every 12 hours ☐ ____ times a day ☐ 1 dose now
☐ every ____ hours, PRN: ________
☐ ____ mL/hr (fluid) ☐ other: ________
Medication concentration *(if indicated, e.g. digoxin)*: ________
Notes:

SCANNED TO PHARMACY
Date: 5/1
Time: 2000
L. Knight
RN Signature
210
IDX order #
5/1 2200
Date/Time:
☒ 12 hour check
☒ 24 hour check 88

Date: 5/2/09
Time: 1730

[signature], M.D.
Physician Signature

Freddy #10915
Printed Name / ID#

☐ Telephone Order
☐ Order read back & verified

RN / RT Signature

☐ Therapeutic interchange NOT permitted

Patient Weight: ____ kg ☐ actual ☐ ideal ☐ adjusted BSA: ____ m2
☒ DISCONTINUE ALL PREVIOUS ORDERS FOR THIS MEDICATION OR FLUID
MEDICATION OR FLUID: Cefoxone
calculation (meds): ☐ ________ / kg / dose ☐ ________ / kg / day
☐ other: ________
DOSE: ________ ☐ grams ☐ mg ☐ mcg ☐ units ☐ other: ________
ROUTE: ☐ IV ☐ IM ☐ SC ☐ PO ☐ NG or GT ☐ ND ☐ PR ☐ Inhaled
☐ Other ________
FREQUENCY: ☐ every ____ hours ☐ ____ times a day ☐ 1 dose now
☐ every ____ hours, PRN: ________
☐ ____ mL/hr (fluid) ☐ other: ________
Medication concentration *(if indicated, e.g. digoxin)*: ________
Notes:

SCANNED TO PHARMACY
Date:
Time:
RN Signature
IDX order #
5/2 1815
Date/Time:
☒ 12 hour check UK
☒ 24 hour check 84

Scanned to Pharmacy
Date/Time/Initials

PATIENT IDENTIFICATION

W[redacted]
N[redacted]
04305493 4M M FH 37373672
PADM ADM ACCT STRT
G[redacted]08

INOVA FAIRFAX HOSPITAL FOR CHILDREN

PEDIATRIC MEDICATION ORDERS

CAT #85335 / R031409 • IFHC-PEDS-ORD • PK50-0F-100

MED0658

1PO

DO NOT USE: U, IU, µg, QOD, QID, **QD/qd**, AU, AS, AD, MS, MSO4, MgSO4, AZT, Nitro drip

Date: 5/2/09
Time: 1730
Physician Signature
Printed Name / ID#
☐ Telephone Order
☐ Order read back & verified
RN / RT Signature
☐ Therapeutic Interchange NOT permitted

Patient Weight: 7 kg ☒ actual ☐ ideal ☐ adjusted BSA: ____ m2
☐ DISCONTINUE ALL PREVIOUS ORDERS FOR THIS MEDICATION OR FLUID
MEDICATION OR FLUID: Bactrim
calculation (meds): ☐ ____ / kg / dose ☒ 20mg / kg / day (TMP component)
☐ other:
DOSE: 45 ☐ grams ☒ mg ☐ mcg ☐ units ☐ other:
ROUTE: ☐ IV ☐ IM ☐ SC ☒ PO ☐ NG or GT ☐ ND ☐ PR ☐ Inhaled ☐ Other
FREQUENCY: ☒ every 8 hours ☐ ____ times a day ☐ 1 dose now ☐ every ____ hours, PRN: ☐ ____ mL/hr (fluid) ☐ other:
Medication concentration *(if indicated, e.g. digoxin)*:
Notes: 1st DC after last dose on 5/5

SCANNED TO PHARMACY
Date:
Time:
RN Signature
IDX order #
Date/Time:
☐ 12 hour check
☐ 24 hour check

Date: 5/4/09 0715 10 days
Time: 5/5/09 0600
Physician Signature
Printed Name / ID#
STAT
☐ Telephone Order
☐ Order read back & verified
RN / RT Signature
☐ Therapeutic Interchange NOT permitted

Patient Weight: ____ kg ☐ actual ☐ ideal ☐ adjusted BSA: ____ m2
☐ DISCONTINUE ALL PREVIOUS ORDERS FOR THIS MEDICATION OR FLUID
MEDICATION OR FLUID: Cyclomydril
calculation (meds): ☐ ____ / kg / dose ☐ ____ / kg / day
☒ other: standard dose
DOSE: 1 drop ☐ grams ☐ mg ☐ mcg ☐ units ☒ other: drop
ROUTE: ☐ IV ☐ IM ☐ SC ☐ PO ☐ NG or GT ☐ ND ☐ PR ☐ Inhaled ☐ Other
FREQUENCY: ☐ every ____ hours ☐ ____ times a day ☐ 1 dose now ☐ every ____ hours, PRN: ☐ ____ mL/hr (fluid) ☐ other:
Medication concentration *(if indicated, e.g. digoxin)*:
Notes: 1 drop each eye, wait 5 min, repeat x 3 start at 9:15am

SCANNED TO PHARMACY
Date:
Time:
RN Signature
#227
IDX order #
5/5/09 1800
Date/Time:
☒ 12 hour check 515 UK
☐ 24 hour check

Date: 5/5/09
Time: 0800
Physician Signature
Printed Name / ID#
STAT
☐ Telephone Order
☐ Order read back & verified
RN / RT Signature
☐ Therapeutic Interchange NOT permitted

Patient Weight: ____ kg ☐ actual ☐ ideal ☐ adjusted BSA: ____ m2
☐ DISCONTINUE ALL PREVIOUS ORDERS FOR THIS MEDICATION OR FLUID
MEDICATION OR FLUID: tetracaine
calculation (meds): ☐ ____ / kg / dose ☐ ____ / kg / day
☐ other:
DOSE: ____ ☐ grams ☐ mg ☐ mcg ☐ units ☐ other:
ROUTE: ☐ IV ☐ IM ☐ SC ☐ PO ☐ NG or GT ☐ ND ☐ PR ☐ Inhaled ☐ Other one bottle at bedside.
FREQUENCY: ☐ every ____ hours ☐ ____ times a day ☐ 1 dose now ☐ every ____ hours, PRN: ☐ ____ mL/hr (fluid) ☐ other:
Medication concentration *(if indicated, e.g. digoxin)*:
Notes: hold at bedside for ophthamology

SCANNED TO PHARMACY
Date: 5/5
Time: 0817
RN Signature
#226
IDX order #
5/5/09 1800
Date/Time:
☒ 12 hour check 515
☐ 24 hour check

PATIENT IDENTIFICATION

W[redacted] G[redacted]08
N[redacted] FH 37373672
04305493 4M M ACCT STRT
PADM ADM

INOVA FAIRFAX HOSPITAL FOR CHILDREN

PEDIATRIC MEDICATION ORDERS

CAT #85335 / R031409 • IFHC-PEDS-ORD • PKGS OF 100

MED0659

** Sputum Culture 28APR2009 08:26 MCRO Final

W[redacted] N[redacted] G

RESPIRATORY CULTURES AND ASSOCIATED TESTS

CULTURE, SPUTUM
ENDOTRACHEAL TUBE

ACCESSION #: MM-09-040189
COLLECTED: 04/28/09 AT 0826
RECEIVED: 04/28/09 AT 1024

STAINS AND PREPARATIONS
04/28/09 1345
FEW WBCS
RARE EPITHELIAL CELLS
MODERATE GRAM POSITIVE COCCI
FINAL REPORT
04/30/09 0933
MODERATE GROWTH OF STAPHYLOCOCCUS AUREUS
MODERATE GROWTH OF STREPTOCOCCUS PNEUMONIAE
SUSCEPTIBILITY TESTING WAS NOT REPEATED ON THIS ISOLATE
BECAUSE IT WAS PERFORMED ON THE SAME ORGANISM FROM A
CULTURE COLLECTED WITHIN 14 DAYS OF THIS ONE
SUSCEPTIBILITY TESTING

S AUREUS	MIC	INTERP
AZITHROMYCIN		S
CIPROFLOXACIN	<=0.5	S
CLINDAMYCIN	<=0.25	S
D-TEST	NEGATIVE	
ERYTHROMYCIN	<=0.25	S
LEVOFLOXACIN	0.25	S
OXACILLIN	0.5	S
SULFA/TRIMETH	<=10	S
TETRACYCLINE	<=1	S
VANCOMYCIN	<=0.5	S

DATE AND TIME OF REPORT: 04/30/2009 AT 0934

** Blood Cult (Aerobic) 28APR2009 05:09 MCRO Final

W[redacted] N[redacted] G

BLOOD CULTURES

CULTURE, BLOOD, AEROBIC
BLOOD OBTAINED BY VENIPUNCTURE

ACCESSION #: BL-09-025412
COLLECTED: 04/28/09 AT 0509
RECEIVED: 04/28/09 AT 0533

FINAL REPORT
05/03/09 0921
NO GROWTH 5 DAYS
DATE AND TIME OF REPORT: 05/03/2009 AT 0921

** Blood Cult (Aerobic) 26APR2009 02:14 MCRO Final

W[redacted] N[redacted] G

BLOOD CULTURES

CULTURE, BLOOD, AEROBIC
BLOOD FROM ARTERIAL DRAW

ACCESSION #: BL-09-024946
COLLECTED: 04/26/09 AT 0214
RECEIVED: 04/26/09 AT 0513

FINAL REPORT
05/01/09 1000

BLOOD CULTURES (Continued)

NO GROWTH 5 DAYS
DATE AND TIME OF REPORT: 05/01/2009 AT 1001

** Sputum Culture 26APR2009 01:44 MCRO Final

W[redacted] N[redacted] G

RESPIRATORY CULTURES AND ASSOCIATED TESTS

CULTURE, SPUTUM
TRACHEAL ASPIRATE
ACCESSION #: MM-09-039436
COLLECTED: 04/26/09 AT 0144
RECEIVED: 04/26/09 AT 0305

STAINS AND PREPARATIONS
04/26/09 0348
RARE WBCS
NO ORGANISMS SEEN
FINAL REPORT
04/27/09 1317
MODERATE GROWTH OF STREPTOCOCCUS PNEUMONIAE
LIGHT GROWTH OF STAPHYLOCOCCUS AUREUS
REFER TO PREVIOUS SUSCEPTIBILITY RESULTS
DATE AND TIME OF REPORT: 04/27/2009 AT 1319

** Sputum Culture 20APR2009 23:42 MCRO Final

W[redacted] N[redacted] G

RESPIRATORY CULTURES AND ASSOCIATED TESTS

CULTURE, SPUTUM
TRACHEAL ASPIRATE
ACCESSION #: MM-09-037895
COLLECTED: 04/20/09 AT 2342
RECEIVED: 04/21/09 AT 0029

STAINS AND PREPARATIONS
04/21/09 0106
FEW WBCS
MANY GRAM POSITIVE COCCI
FEW GRAM POSITIVE RODS
RARE GRAM NEGATIVE RODS
FINAL REPORT
04/24/09 1406
HEAVY GROWTH OF STAPHYLOCOCCUS AUREUS AND STREPTOCOCCUS PNEUMONIAE
SUSCEPTIBILITY TESTING

S AUREUS	MIC	INTERP
AZITHROMYCIN		S
CIPROFLOXACIN	<=0.5	S
CLINDAMYCIN	<=0.25	S
D-TEST	NEGATIVE	
ERYTHROMYCIN	<=0.25	S
LEVOFLOXACIN	<=0.12	S
OXACILLIN	0.5	S
SULFA/TRIMETH	<=10	S
TETRACYCLINE	<=1	S
VANCOMYCIN	<=0.5	S

S PNEUMO	MIC	INTERP
AMPICILLIN		S

1DAILY

Desired Outcome	Time 08 Initials BA	Time 20 Initials JV
Respiratory	☒ Outcome met	☐ Outcome met
RR at rest Infant 30-60 Child 18-40 Adolescent 12-16	Respirations: ☐ Shallow ☐ Labored ☐ Grunting ☐ Nasal Flaring ☐ Stridor ☐ Apneic ☐ Retractions ____ ☐ Dyspnea Cough: ☒ Productive ☐ Non-Productive ☐ Sputum ____ ☒ UAC	Respirations: ☐ Shallow ☐ Labored ☐ Grunting ☐ Nasal Flaring ☐ Stridor ☐ Apneic ☐ Retractions ____ ☐ Dyspnea Cough: ☒ Productive ☐ Non-Productive ☐ Sputum ____ ☐ UAC
Respirations unlabored & regular without use of accessory muscles. Lungs clear bilaterally without adventitious sounds. No sputum production. Nail beds and mucous membranes are pink.	Tracheostomy ☐ Shiley ☐ Bivona ☐ Other ☐ Neo ☐ Peds ☐ Adult ☐ Size ____ ☐ Cuffed ☐ Uncuffed Last Δ'd ____ Site condition ____ ☐ Precautions at Bedside Breath Sounds: R L Anterior — R L Posterior ☐ ☐ Crackles — ☐ ☐ Crackles ☐ ☐ Wheezes Ins/Exp — ☐ ☐ Wheezes Ins/Exp ☒ ☒ Rhonchi — ☒ ☒ Rhonchi ☐ ☐ Diminished — ☐ ☐ Diminished ☐ ☐ Absent — ☐ ☐ Absent Oxygen Source: ☒ % 21 ☒ Route RA ☒ SaO_2 95% Chest Tubes: ☐ Last Dsg Δ ____ ☐ Precautions at Bedside Suction: ☐ Water Seal ☐ Wall Suction ☐ Cm Suction ____ CT Position: Anterior ☐ R ☐ L Lateral ☐ R ☐ L Mediastinal ☐ R ☐ L CT Drainage: ☐ Serous ☐ Sanguinous ☐ Serosanguinous ☐ Purulent ☐ Tidaling ☐ Airleak ☐ Crepitus ☐ Location Other: ____	Tracheostomy ☐ Shiley ☐ Bivona ☐ Other ☐ Neo ☐ Peds ☐ Adult ☐ Size ____ ☐ Cuffed ☐ Uncuffed Last Δ'd ____ Site condition ____ ☐ Precautions at Bedside Breath Sounds: R L Anterior — R L Posterior ☐ ☐ Crackles — ☐ ☐ Crackles ☐ ☐ Wheezes Ins/Exp — ☐ ☐ Wheezes Ins/Exp ☒ ☒ Rhonchi — ☒ ☒ Rhonchi ☐ ☐ Diminished — ☐ ☐ Diminished ☐ ☐ Absent — ☐ ☐ Absent Oxygen Source: ☐ % 21 ☐ Route RA ☐ SaO_2 99% Chest Tubes: ☐ Last Dsg Δ ____ ☐ Precautions at Bedside Suction: ☐ Water Seal ☐ Wall Suction ☐ Cm Suction ____ CT Position: Anterior ☐ R ☐ L Lateral ☐ R ☐ L Mediastinal ☐ R ☐ L CT Drainage: ☐ Serous ☐ Sanguinous ☐ Serosanguinous ☐ Purulent ☐ Tidaling ☐ Airleak ☐ Crepitus ☐ Location Other: ____
Cardiovascular	☒ Outcome met	☒ Outcome met
Heart rate: Neonate 80-180 Infant 75-160 Child 60-110 Adol 60-90	Edema: ☐ Generalized ☐ Periorbital ☐ Sacral ☐ Extremity ____ ☐ Ascites Heart Rhythm: ☐ Irregular ____ ☐ Murmur ☐ Rub	Edema: ☐ Generalized ☐ Periorbital ☐ Sacral ☐ Extremity ____ ☐ Ascites Heart Rhythm: ☐ Irregular ____ ☐ Murmur ☐ Rub
Pulses palpable Cap refill <3 sec No edema.	Pacemaker: ☐ Permanent ☐ Temporary ☐ Rate: ____ Telemetry ☒ Yes ☐ No Pulses: (+) pulses	Pacemaker: ☐ Permanent ☐ Temporary ☐ Rate: ____ Telemetry ☒ Yes ☐ No Pulses: (+)

Arterial Pulses DA		B	R	F	DP	PT	CAROTID
	R						
	L						

W [redacted]
N [redacted]
G [redacted] /08
04305493 5M M FH 37373672
PADM ADM 04/20/09 ACCT STRT

INOVA HEALTH SYSTEM
PEDIATRIC PATIENT DAILY ASSESSMENT

Date: 5/3/09

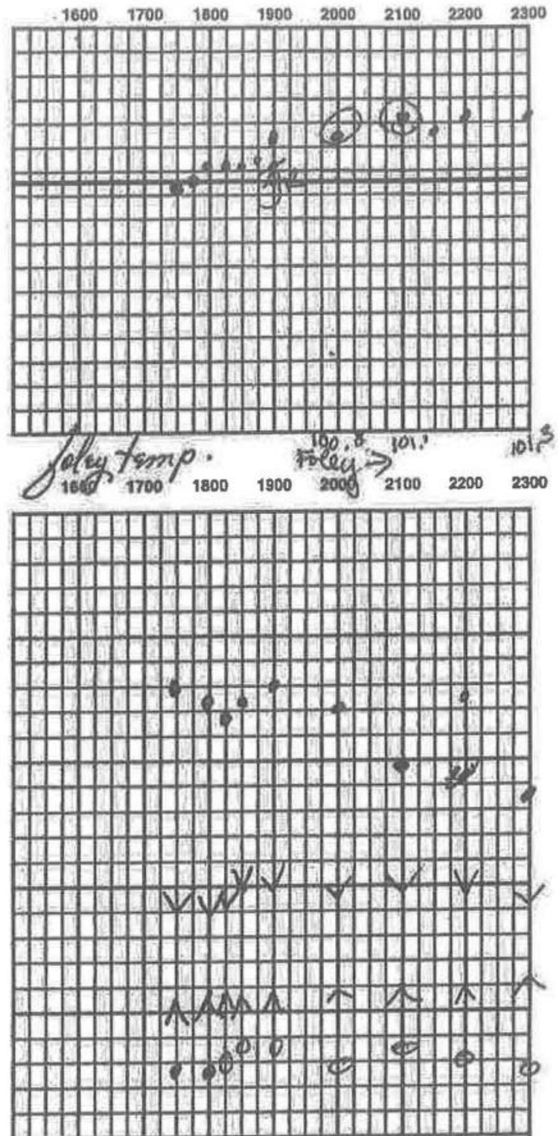
Page 1 of 7

CAT # 86138 / R031109

MR 24-25

MED0837

W[redacted]
N[redacted]
04305493 4M M FH G[redacted]08
37373672
PADM ADM ACCT STRT



Admit Date 4/10

OR Date

Height 65cm

Head Circ (Infants under 2 yrs) 43.5 cm

Ett/Trach size (cuffed/uncuffed) 3.5

Taped at 10cm @ lip

When placed

Retaped on

BP: T Art / V Cuff; RESP °; HR •; Temp •

	1600	1700	1800	1900	2000	2100	2200
MABP / CUFF MEAN		67 70 70	67	77	72	78	
PAIN SCALE (1-10)		Ø		Ø	Ø	Ø	Ø

HEMODYNAMICS	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200
CVP															
LAP															
PAS / PAD															
MPAP															
PCWP															
SVO2															
EtCO2										34	38	38	41	42	40
O2 Sat										100	100	100	100	100	100
ICP															
CPP															
RIPS: None															

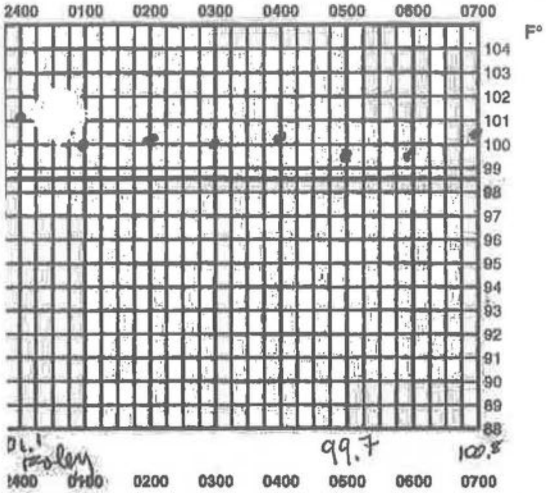
INOVA HOSPITAL FOR CHILDREN

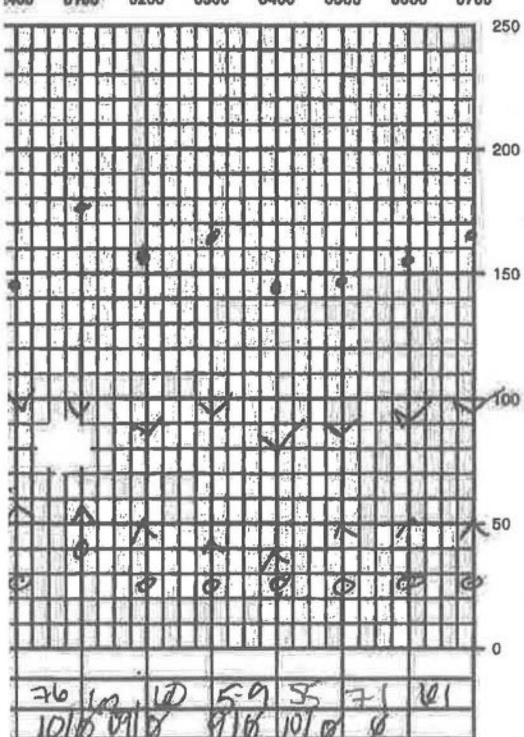
PICU Flowsheet

page 1 of 4

RN [illegible] / SK Date 4/20

MED0907





2400	0100	0200	0300	0400	0500	0600	0700
40	39	39	38	39	36	37	36
100	100	100	100	100	100	100	100

Nurses' Progress Notes

1800. Pt admitted @ 1930 from emergency room. Pt placed on ventilator and [illegible] assessment done by admitting ~~pt~~ bedside RN. Pt. also examined by Dr. Hundl. Assessment ongoing.
K Burkhardt RN
Medical orders pending — KB —
4/21/09 0420 #[illegible]: Pt remains on servo via ETT. Awakes spontaneously and bucks vent, fighting c arms & legs. ~~[illegible]~~ Pupils remain equal & reactive to light. Fontanel full to flat. MD aware & visualized pt. P: Go to CT scan @ 0500. Versed & Fent PRN administered to keep pt c ETT. Neuro consulting. CXR while intubated now. Bone survey in AM shift c Peds radiology pt. [illegible] V @ 4°. Run NS as ordered via MD. Sputum & urine cx sent. Results pending. Ceftriax. started per MD. Tylenol administered for fever. Mom & dad @ bedside, appropriate. Will cont to monitor, Attain coags, BMP, CBC. —— McBath[illegible]

MED0908

D = [illegible]
Previous 24°

I

O

Today's Weight
60 Kg

Yesterday's Weight

INOVA HOSPITAL FOR CHILDREN
PICU Flowsheet
page 1 of 4

RN [illegible]
RN [illegible]
Date 4/20

Assistive Devices
T - TEDS
A - Air Mattress
S - Splints
C - Compression Device

		0800	0900	1000	1100	1200	1300	1400	1500	8 hr Total	1600	1700	1800	1900	2000	2100	2200
INTAKE												50	30/100	50/150	50/200	50/250	27/277
	N.S. D5½NS + 20K																
	Meds																
	TOTAL INTAKE ➤																TOTAL INTAI
OUTPUT	URINE												34/54		42/76	10/86	4/90
	STOOL/GUIAC												ϕ				
	GASTRIC GUIAC/PH																
	CHEST TUBE																
	TOTAL OUTPUT ➤																TOTAL OUTPU
PRN MEDS	Tylenol																
	Versed																
	Fentanyl																
	HEPARIN FLUSH																
MISC	OXIMETRY PROBE SITE												AL		Δ		
	ACCUCHECK																172
	HWE/C												✓	✓	✓	✓	✓
	PROTECTIVE / SAFETY DEVICE														✓		
	CIRC CHECK																✓
	ASSISTIVE DEVICE																

[redacted] 08
G
FH 37373672 ACCT STRT
M
4M ADM
[redacted]
W N 04305493 PADM

CAT #81213 / R5-01 • PKGS '00

	2400	0100	0200	0300	0400	0500	0600	0700	8 hr Total
	30	30/100	30/90	30/120	30/120	30/80	30/110	30/140	240
									13
TOTAL INTAKE ➤									243
	50	30/80		40/120	20/140	15/155	5/110	7/107	117 549
TOTAL OUTPUT ➤									167 267

24°

0205 0515 0430 0830
0.3mg 0.3mg 0.1mg 0.2mg
0200 0515
7mg 7mg

119

0515
115

Room Check	0700 - 1900	1900 - 0700
BAG / MASK / SUCTION / DRUG SHEET	SJR	MKB
SIDE RAILS / BED POSITION	SJR	MKB
Alarm Parameters ON	SJR	MKB

2 RN Signatures to verify IV Drip rates

0700 ● / ●

1900 ● / ●

VENTILATION

	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200
O_2 SOURCE													SEND						
FIO_2										30%			30%						
MODE										SIMV VCRS			SIMV VCRS						
RATE (IMV)										28			28						
TV										60			60						
PIP / PEEP										5			5						
PS										10			10						
SaO_2 (PULSE OX)																			
$ETCO_2$																			
pH																			
PCO_2																			
PO_2																			
HCO_2																			
BE																			
Art O_2 Sat (calc)																			
Art O_2 Sat (dir.)																			
VEN O_2 Sat (dir.)																			
NEB/ CPT																			
SUCTION											✓		✓	✓	✓			✓	✓

GLASGOW COMA SCALE

	CHILD/ADOLESCENT	INFANT	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0
EYES	4 Spontaneous 3 Open to Speech 2 Open to Pain 1 Remain Closed											1			1	1	3	1	3	
VERBAL	5 Oriented 4 Confused 3 Words 2 Sounds Only 1 No Response	Coos/Babbles Irritable Cry Cries to Pain Moans to Pain										1 ETT			1 EH	1	1	1	1	
MOTOR	6 Obeys Commands 5 Localizes Pain 4 Withdraws 3 Abnormal Flexion 2 Extension 1 No Response	Spontaneous Movement Withdraws to Touch Withdraws to Pain SEDATED Y / N										5			5	5	5	1	5	
	TOTAL											Y (SD)			HLED	N	TV	→	→	
PUPILS	RIGHT: Size/Reaction R											7			7	7	9	3	9	
	LEFT: Size/Reaction L											3R 3L			3R 3R	3R 3R	3R 3R	3R 3R	3R 3R	
Fontanelle: FI - Flat Fu - Full B - Bulging T - Tense S - Sunken												FU			FI	FI	FI	FI	FI	
ARMS	5 Normal 2 Does Not Break Gravity R 4 Slightly Weak 1 Flicker 3 Breaks Gravity 0 No Motor Response L											1			3	3	3	1	3	
LEGS	5 Normal 2 Does Not Break Gravity R 4 Slightly Weak 1 Flicker 3 Breaks Gravity 0 No Motor Response L											1			1	3	3	1	3	
COUGH / GAG	+ OR -											1			1	1	1	1	1	
SUCK / SWALLOW	+ OR -											1			1	1	1	1	1	
PAIN SCALE *circle method:*		cries / faces / flacc / linear									cries / faces / flacc / linear									
												+/+			+/+	+/+	+/+	+/+	+/+	
												UTA			UTA	UTA	UTA	UTA	UTA	

☐ System Assessed, No Problem Identified

1. Respirations: ☐ Shallow ☐ Labored ☐ Nasal Flaring ☐ Stridor ☐ Grunting ☐ Periodic

RMP YB INIT 1745

MED0911

0500 0600 0700

0500 0600 0700

0 0400 0500 0600 0700

4 4 2 2

1 1 1 1

6 6 5 4

N N N N

11 11 8 7

3B 3S 3F 3B

3B 3S 3F 3B

Fup Fup Fup

4 3 3 1

4 3 3 1

3 3 1 1

3 3 1 1

/ flacc / linear

INIT NO PROBLEM

Lab Values

TIME	1535	4/26 0445					
Glu	220	103					
BUN	11	3					
Creat	0.4	0.2					
Na	140	137					
K	3.8	3.7					
Cl	105	106					
CO_2	19	23					
~~ICA~~ CA	9	9.2					
Hgb	8.8	8.5					
Hct	26.9	25.3					
Plts	318	271					
~~WBC~~	~~11.47~~ 3.51	10.6 ~~3.4~~					
PT		13.7					
PTT							
Glu / Ket							
Sg / pH							
bld / prot							

Refe ... range for unit based lab tests		
Accucheck: 70-100 mg/dl		
URINE DIPSTICK		
glucose	–	negative
bilirubin	–	negative
ketone	–	negative
blood	–	negative
ph	–	5.0-8.0
protein	–	neg.-trace
sp. gravity	–	1.001-1.035
occult blood in stool	–	negative
occult blood in gastric content	–	negative

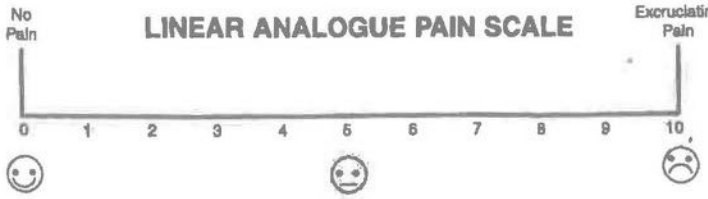
Hours Post Dose →						
DRUG LEVELS						

PUPIL SCALE

B = Brisk S = Sluggish N = Non-react

LINEAR ANALOGUE PAIN SCALE

No Pain — Excruciating Pain



INOVA HOSPITAL FOR CHILDREN

PICU Flowsheet

page 3 of 4

RN RN

Date 4/26

0700-1900 INITIAL	1900-0700 INITIAL

MED0912

RESPIRATORY

Consistency: ☐ Thin ☐ Thick ☐ Frothy ☐ Tenacious

4. Breath Sounds: Right side Clear Left side Clear (+) air leak

1. Clear 2. Crackles 3. Inspiratory wheezes 4. Exp. wheezes 5. Rhonchi 6. Stridor 7. Diminished 8. Absent

5. Chest Tubes: Type of Device ____ CM suction ____ ☐ Water Seal
Location ____ ☐ Tidaling ☐ Air leak ____ ☐ Straight Drainage None
Character of Drainage ☐ Serous ☐ Sero Sanguinous ☐ Sanguinous ☐ Cloudy

Comment Cont. Eff 2L/02 Sat monitoring

CARDIOVASCULAR

☐ System Assessed, No Problem Identified TIME 1745 INIT JB

1. Heart Rhythm: ☐ NSR ☐ Sinus Brady ☑ Sinus Tachycardia @ this time
☐ SVT ☐ Ventricular Dysrhythmia ☐ Junctional/Nodal
Pacemaker: ☐ Temporary ☐ Permanent ☐ Transvenous ☐ Epicardial
☐ Transcutaneous Mode ____ Rate ____
MA: AO ____ VO ____ Sensitivity A ____ V ____ AV Delay ____

2. Pulses: 0-Absent 1 Weak 2 Normal 3 Bounding D-Doppler

Pulse	B	R	F	DP	PT	Carotid
R	2	2		2	2	
L	2	2		2	2	

CAPILLARY REFILL IN SECONDS

CFT: RUE	~3 sec	LUE	
RLE		LLE	~3 sec

3. Heart Tones: ☐ Active Precordium ☑ Normal ☐ Murmur
☐ Gallup ☐ Rub ☐ Distant PMI ____

4. Edema: ☐ Generalized ☐ Extremity ☐ Sacral ☐ Periorbital
☐ Other ____ ∅ noted

5. Vascular Catheters:

Line Type	Location	Date of Insertion	Device	Site Condition
PIV	24g (R) foot	4/20	IV fluids → pump	
PIV	24g (R) hand	4/20	H.L	

PA catheter CM insertion ____ CM Sheath ____

Comment Cont. CR. monitoring & limits set & alarms on

INTEGUMENTARY

☐ System Assessed, No Problem Identified TIME 1745 INIT JB

1. Skin Turgor: ☐ Poor ☐ Taut ☑ Elastic
2. Skin Temperature: ☐ Cool ☐ Clammy ☐ Diaphoretic ☑ Warm ☐ Hot
3. Skin Color: ☑ Pale ☐ Mottled ☐ Cyanotic ☐ Jaundiced ☑ Pink ☐ Red/Flushed
4. Rash/Lesions: ∅ Location / Type ____
5. Pressure Ulcers: ∅ Site ____ Site in cm ____
Stage: ☐ Red Area ☐ II Partial Thickness ☐ III Full Thickness ☐ Penetration to Muscle

Incision/Wounds/Drains:
location / Condition: None
Comment

SSS
BRADEN SCALE:
Total Score: 18

16 - 16	Low Risk
12 - 14	Mod Risk
≤ 11	Hi Risk

GI / GU

☐ System Assessed, No Problem Identified TIME 1745 INIT JB

1. Abdominal Palpitation: ☑ Soft ☐ Firm ☐ Distended ☐ Tender ☐ Rigid ☐ Girth ____
2. Bowel Sounds: ☑ Active ☐ Hyperactive ☐ Hypoactive ☐ Absent
3. Gastric Tube: Type OG Size 18FR Measures (cm) ____ ☐ To suction ☐ To gravity drainage ☐ Feeding (intermittent/continuou
Type ____ Size ____ Measures (cm) ____ ☐ To suction ☐ To gravity drainage ☐ Feeding (intermittent/continuou
drainage: color ____ gulso ____
4. Urine Catheter: ☐ External ☐ Suprapubic ☑ Indwelling size 8FR Date Inserted 4/20
color ____ ☐ Cloudy ☐ Sediment ☐ Fruity Smell ☐ Foul Smell

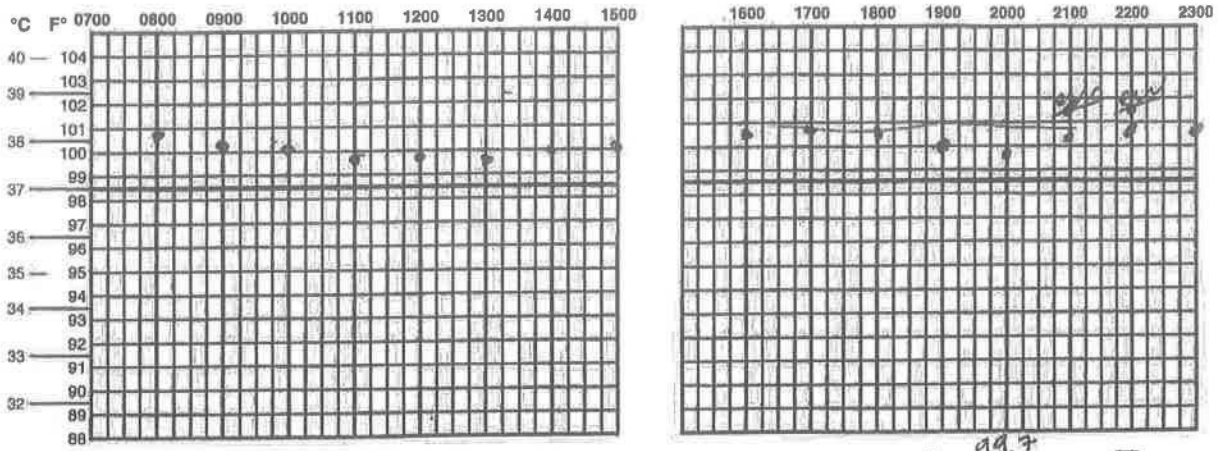
Comment

observed
oarse bilaterally
Ø
agree
INIT MKB ☐ NO PROBLEM
agree
agree
agree
agree
ag
ee
INIT MKB ☐ NO PROBLEM
agree
+
fever@this time
INIT MKB ☐ NO PROBLEM
ee
pale yellow urine
a ed +

Section	Item		
N	Comments:		
NUTRITION	Diet: NPO	KB	MKB
	Formula:		
	☐ NG ☐ ND/NJ ☐ GT ☐ po		
	☐ Total feed ☐ Needs assistance ☐ Feeds self		
ALLERGIES	NKDA	SJR	MKB
PSYCHOSOCIAL	☑ Communications Barrier BETT	SJR	MKB
	☐ Unable to assess: ☐ Pt. ☐ Family		
	☐ Coping Ineffective: ☐ Pt. ☐ Family		
	☐ Fears:		
	Pain ☐ Pt. ☐ Family		
	Dying ☐ Pt. ☐ Family		
	Being Alone ☐ Pt. ☐ Family		
	☐ Emotional State:		
	Anxious ☐ Pt. ☑ Family	SJR	MKB
	Agitated ☐ Pt. ☐ Family		
	Tearful/Crying ☐ Pt. ☑ Family	SJR	
	Euphoric		
	☑ Parents: ☐ Called ☑ Visited	SJR	MKB
	☐ Pt./Parent Teaching ☐ Return demonstration		
	Comments:		
NURSING CARE / PROCEDURES	TRANSDUCERS: level / calibrated		
	Activity: ☑ total care ☐ need assistance ☐ self care	SJR	MKB
	HOB: ☐ flat ☑ 30° ☐ 45° ☐ 90°	SJR	MKB
	☑ other high falls	SJR	MKB
	Bedrest / Turn Q2°	SJR	MKB
	Chair / HELD		
	Ambulate ☐ on own ☐ with assist		
	ROM		
	Protective Device / RELEASE Q2°		MKB
	Seizure Precautions	High Falls Precautions	
	HYGIENE: Bath		
	Oral Hygiene		MKB
	Peri / Foley Care	SJR	MKB
	Skin Care	SJR	MKB
	Gastric Tube Care		
	Feeding Bag Rinsed / Changed		
	Trach Care / Trach Changed		
	Cervical Collar Site Care		
	Line Tubing Changed / Injection Cap Changed		
	Carrier System Changed		
	IV Started / Location		
	PREP for test or procedure		
	x ray		MKB
	other CPS/police/photos taken by PD	CT 0500	MKB
	NURSING CARE > 16 hrs/day		MKB

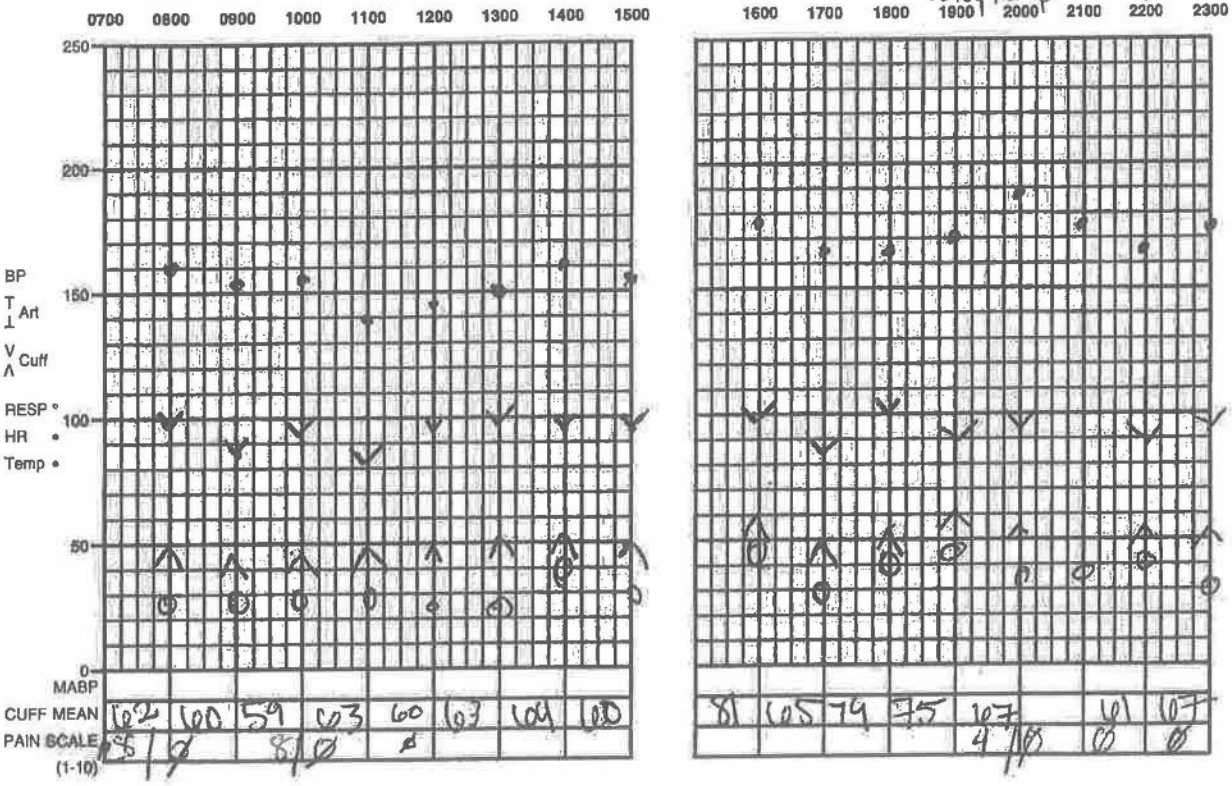
INOVA HOSPITAL FOR CHILDREN
PICU Flowsheet
page 4 of 4
RN KB/SJR
RN MKB
Date 4/20

G [redacted]/08
FH 37373672
ACCT STRT
[redacted] 4M M
W [redacted] 04305493
ADM
PADM



Admit Date
4/20/09
OR Date

Height
65cm
Head Circ
Infants under 2 yrs
43.5cm
Ett/Trach size
cuffed/uncuffed
3.5
Taped at
12cm@lip
When placed
4/20/09
Retaped on
4/20/09



INOVA HOSPITAL FOR CHILDREN
PICU Flowsheet
page 1 of 4
RN LCT
RN MKB
Date 4/21/09

		0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200
HEMODYNAMICS	CVP															
	LAP															
	PAS / PAD															
	MPAP															
	PCWP															
	SVO_2															
	$EtCO_2$	36	37	36	40	38	38	37	37							
	O_2 Sat	100	100	100	100	100	100	100	100	100	100	100	99	95	97	100
	ICP															
	CPP															
RIPS																

MED0915